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LUCEY,MARILYN: BIDMC Notes Detail - CCC Record #1518504

Letter - CCC

February 12, 2003

Myron Falchuk, MD
Division Of Gastroenterology-Gi/West
110 Francis St, Ste 8c
Boston, MA 02215

RE: Marilyn Lucey (BID# 151-85-04)

Dear Dr. Falchuk:

Thank you for the privilege of seeing your patient, Ms. Marilyn Lucey. As you know, she has a long history of Crohn's disease. She was originally diagnosed in 1982 when she underwent an appendectomy. She has also had adhesiolysis in 1982 and a resection for fistulous disease in 1983. She did well for a while until she had recurrence with an abscess and resection again in 1990. She required a further resection and ileotransverse colostomy in 1990. She subseqeuntly had another resection in 1991.

It comes as no surprise that, given her resection, she has teetered on short bowel syndrome. She has managed to maintain her weight however it has involved more than simple food management. She currently states that she can have anywhere from 20 to 30 bowel movements a day. Her present management includes Questran, B12 shots, Imipramine and Asacol.

In review of your endoscopic findings, it appears she has peri-anastomotic disease again. I have counseled her regarding her short gut and the need for an extremely limited resection of her persistent disease. If she had not had increasing symptoms since November, it would seem to prudent to agree with your previous strategy of tempering surgical need. However, it seems that her symptoms have increased since Christmas time and again in January and into February.

I have counseled her regarding a limited resection. I have also mentioned that with limited resections we may leave residual Crohn's disease behind. This greatly increases her risk of fistula and abscess formation in the perioperative period. She understands this risk and the risk of the procedure along with

it's other complications of general anesthesia and surgery.

Please don't hesitate to call if you have any questions.

Most sincerely,

Frank Opelka, MD,FACS
FO/bt

Written by OPELKA,FRANK on 02/12/03, signed on 02/25/03

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LUCEY,MARILYN: BIDMC Notes Detail - CCC Record #1518504

Operative Note #483516 - CCC
Name: LUCEY, MARILYN Unit No: 1518504

Service: Date: 02/20/2003

Date of Birth: Sex: F

Surgeon: F. OPELKA, M.D. 02-911

Assistant: JULIE FUCHS, M.D., Resident present.

PREOPERATIVE DIAGNOSIS: Ileal obstruction.

POSTOPERATIVE DIAGNOSIS: Ileal obstruction.

PROCEDURE: Ileocolic resection and anastomosis.

COMPLICATIONS: None.

ANESTHESIA: General.

ATTESTATION: I was present for the entire procedure.

DESCRIPTION OF PROCEDURE: The patient was brought to the Operating Room and placed on the operating table in the supine position. She underwent general anesthetic induction with oral endotracheal intubation without complication. She was prepped with Betadine prep and draped in a sterile fashion. She had a Foley catheter placed under sterile technique.

Through her previous midline incision, the abdomen was entered. Upon exploring the abdomen, we lysed adhesions throughout the abdomen for approximately one hour. After the lysis of adhesions was completed, we were able to identify her ileocolic anastomosis. She did not appear to have acute Crohn's disease, but her most recent clinical course had been one of obstructions and her colonoscopy demonstrated some narrowing at this point. With no other evidence of acute disease or fistulas, we then excised just the ileocolic anastomosis.

This area was identified both proximally and distally to the anastomosis. A linear cutter was fired, dividing the ileum and the colon. In this isolated ileocolic segment, the mesenteric vessels were identified, doubly clamped, divided and suture ligated. A side-to-side ileocolic anastomosis was performed using a running 3-0 PDS suture. Once the side-to-side anastomosis had been performed, there was no significant mesenteric defect to be closed. The abdomen was then copiously irrigated.

The sponge, needle and instrument count was correct. Clean instruments were used. The surgeon's gown and gloves were changed for closure.

A separate film was placed in the midline wound and the midline wound was then closed with running double-stranded PDS suture. The subcutaneous tissues were copiously irrigated. Skin staples were applied and the occlusive dressings applied to the incisions.

The patient was extubated in the Operating Room and taken to Recovery in stable condition.

F. OPELKA, M.D. 02-911

Dictated By: F. OPELKA, M.D.

MEDQUIST36

D: 02/20/2003 10:19
T: 02/20/2003 16:19
JOB#: 27446

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LUCEY,MARILYN: BIDMC Notes Detail - CCC Record #1518504

Discharge Summary #484603 - CCC
Name: LUCEY, MARILYN Unit No: 1518504

Admission Date: 02/20/2003 Discharge Date: 03/01/2003

Date of Birth: 03/23/1961 Sex: F

Service: COLORECTAL SURGERY

HISTORY OF PRESENT ILLNESS: This is a 41 year old female with a history of Crohn's disease who is status post multiple abdominal surgeries and bowel resection for abscess, fistula and adhesions, her last surgery being 1991. She was noted on colonoscopy to have a narrowing in the distal transverse colon near a previous side to side colocolic anastomosis. The patient had also been having considerable diarrhea prompting her to seek medical evaluation. She had opted for elective ileocolic resection with anastomosis.

PAST MEDICAL HISTORY:
1. Crohn's disease.
2. Status post muscle pull.
3. Abdominal surgeries for fistula, adhesions and abscesses.
4. Status post knee surgery.
5. Status post appendectomy.

MEDICATIONS ON ADMISSION:
1. Questran.
2. Imipramine 50 mg p.o. three times a day.
3. Vitamin B12.
4. Asacol.

ALLERGIES: No known drug allergies.

SOCIAL HISTORY: Recently stopped smoking after a twenty pack year history. Occasional alcohol.

HOSPITAL COURSE: The patient was taken to the operating room on 02/20/03, where she underwent an ileocolic resection with anastomosis under general endotracheal anesthesia. The patient tolerated the procedure well and there were no intraoperative complications. Her postoperative course was significant for a postoperative ileus which slowly resolved. Her nasogastric tube was eventually removed on postoperative day number six. She was started on clears postoperative day number seven and advanced from there on to a regular diet which she tolerated without any problems. She was deemed stable for discharge to home on postoperative day number nine.

CONDITION ON DISCHARGE: Good.

DISCHARGE STATUS: The patient will be discharged to home without services.

DISCHARGE INSTRUCTIONS: No heavy lifting. Drink plenty of

liquids. The patient is to follow-up with Dr. Opelka in ten to fourteen days.

DISCHARGE DIAGNOSES:
1. Crohn's disease.
2. Status post ileocolic resection with anastomosis.
3. Postoperative ileus resolved.

MEDICATIONS ON DISCHARGE:
1. Percocet one to two tablets p.o. q4-6hours p.r.n.
2. Colace 100 mg one twice a day p.r.n., hold for loose stools.

FRANK G. OPELKA, M.D., 02-911

Dictated By: MELANIE EDWARDS, M.D.

MEDQUIST36

D: 03/01/2003 10:44
T: 03/01/2003 18:05
JOB#: 31181

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LUCEY,MARILYN: BIDMC Notes Detail - CCC Record #1518504

Letter - CCC

March 17, 2003

Myron Falchuk, MD
Division Of Gastroenterology-Gi/West
110 Francis St, Ste 8e
Boston, MA 02215

RE: Marilyn Lucey (BID# 151-85-04)

Dear Dr. Falchuk:

I am happy to report that Ms. Lucey has done well after undergoing ileocolic resection for Crohn's stricture. Recently she has noted mild tenderness to the left of the mid-abdomen and some diarrheal stools. She has had a reasonable result with Questran, however, the tenderness persists.

On examination today, the wound is well healed. She has no peritoneal finds. She does have a palpable fullness to the left just above the periumbilical area. It is separate from the abdominal incision and appears to be unrelated to an incisional hernia. It is relatively immobile and somewhat sensitive. Currently she takes no medication for her Crohn's disease. She had been on therapy but has discontinued all therapy at this time. She is familiar with her previous course of Remicade and Asacol.

I have scheduled her for a CAT scan to make sure there is no other intra-abdominal process. I have also suggested that she contact you regarding further continuation or not of any therapy for Crohn's prevention. I realize this is always a questionable issue, but I will leave it in your hands.

Sincerely,

Frank G. Opelka, MD

FGO/jh

Written by OPELKA,FRANK on 03/17/03, signed on 03/21/03

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LUCEY,MARILYN:BIDMC Radiology Detail - CCC Record #1518504

FINAL REPORT

INDICATION: Left upper quadrant abdominal pain.

COMPARISON: None.

TECHNIQUE: Multiple axial images from the lung bases to the pubic symphysis were obtained following the administration of oral contrast as well as 150 cc of Optiray at the patient's request.

ABDOMEN WITH CONTRAST: A 2-mm non-calcified nodule is noted at the right lung base posteriorly. There are no other focal lung base abnormalities. There are no pleural effusions.

The liver, spleen, gallbladder, adrenal glands, and kidneys are within normal limits. There is the possible appearance of an annular pancreas and slightly thickened proximal duodenum. The duodenum is slightly elongated and more laterally located than would be expected. The opacified loops of bowel are otherwise unremarkable. There is no free abdominal fluid.
In addition there is inflammatory stranding of the fat in the mid abdomen adjacent to surgical clips in the bowel (pt is post ileo colectomy) which may be post operative.

PELVIS WITH CONTRAST: The bladder, distal ureters, uterus, adnexa, and pelvic loops of bowel are unremarkable. There is no inguinal or pelvic lymphadenopathy. There is no free pelvic fluid.

BONE WINDOWS: There are no suspicious lytic or sclerotic bony lesions.

IMPRESSION: 1) Possible annular pancreas and thickened proximal duodenum. These could be better evaluated with MRI.
2) 2-mm right lung base nodule which is non-calcified, and for which a three-month follow-up CT scan is suggested.
3) inflammtory stranding mesentery, probably related to recent surery as described above.
THE STUDY AND THE REPORT WERE REVIEWED BY THE STAFF RADIOLOGIST.
DR. JENNIFER M. CUTTS
DR. MARTINA M. MORRIN

Approved: TUE MAR 25,2003 2:56 PM
Procedure Date:03/19/03

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LUCEY,MARILYN:BIDMC Radiology Detail - CCC Record #1518504

FINAL REPORT

INDICATION: Crohn's disease, multiple resections, now with left upper quadrant mass, ? adhesions.

SMALL BOWEL FOLLOW THROUGH STUDY: The patient is s/p semicolectomy. The ileocolonic anastomosis is in the left upper quadrant. There is no evidence of obstruction. Probable normal haustration is demontrated in the proximal end of the remaining colon.

In the pelvis, apparent extraluminal collection of contrast is noted adjacent to the colon. There appears to be possibly two sinus tracts connecting this collection to the adjacent colon. This collection demonstrates an ill-defined irregular contour.

IMPRESSION: The palpable mass lesion in the left upper quadrant appears to correspond to haustration seen proximal end of remaining colon at the anastomotic site.

Probable sinus tracts from sigmoid colon in the pelvis connected with extraluminal contained collection of contrast. If the patient has had prior outside barium studies, comparison can be made. Otherwise, barium enema study would be helpful for further evaluation.

THE STUDY AND THE REPORT WERE REVIEWED BY THE STAFF RADIOLOGIST.
DR. JINGBO ZHANG
DR. ANN MCNAMARA

Approved: MON MAR 31,2003 9:51 AM
Procedure Date:03/27/03

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LUCEY,MARILYN: BIDMC Notes Detail - CCC Record #1518504

Letter - CCC

April 9, 2003

Myron Falchuk, MD
Division Of Gastroenterology-Gi/West
110 Francis St, Ste 8e
Boston, MA 02215

RE: Marilyn Lucey (BID# 151-85-04)

Dear Dr. Falchuk:

I saw Miss Marilyn in follow-up after her previous ileocolic resection. She has continued to do well. Currently she only has an occasional left lower quadrant discomfort. Her bowel function has returned to her baseline Crohn's bowel function. She has no nausea or vomiting, no fevers or chills.

In review of the radiographic abnormality, I think that it is deserving of a short course trial of gram negative and anaerobic coverage. We have started her on Levaquin and Flagyl to treat this. I will follow her and see her over the next month in follow-up.

Please don't hesitate to call if you have any questions.

Most sincerely,

Frank Opelka, MD, FACS
FO/bt
cc
Mary Delaney, MD

Written by OPELKA,FRANK on 04/09/03, signed on 04/16/03

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LUCEY,MARILYN: BIDMC Notes Detail - CCC Record #1518504

Letter - CCC

April 25, 2003

Myron Falchuk, MD
Division Of Gastroenterology-Gi/West
110 Francis St, Ste 8e
Boston, MA 02215

RE: Marilyn Lucey (BID# 151-85-04)

Dear Dr. Falchuk:

I saw Marilyn Lucey in follow-up once again for her ileocolic resection. She had a course of antibiotics and her abdominal pain disappeared. As the antibiotics faded, she started appreciating left mid-abdomen and left lower quadrant discomfort again. At this point I have scheduled her for a CAT scan to assess this intra-abdominal problem. We will attempt to facilitate this with rectal contrast.

Please do not hesitate to call if you have any questions.

Sincerely,

Frank G. Opelka, MD

FGO/jh

cc

Mary Delaney, MD

Written by OPELKA,FRANK on 04/25/03, signed on 05/09/03

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LUCEY,MARILYN: BIDMC Notes Detail - CCC Record #1518504

Letter - CCC
May 9, 2003

Myron Falchuk, MD
Division Of Gastroenterology-Gi/West
110 Francis Street, Suite #8e
Boston, MA 02215

RE: Marilyn Lucey (BID# 151-85-04)

Dear Myron:

I had the privilege of seeing Marilyn Lucy in followup. She still had some vague abdominal complaints that are not quite descript for a definitive or discrete problem. She underwent a CT scan to evaluate this.

The primary problems that she has relates to bloating discomfort whereby she actually has to loosen her clothing to tolerate the discomfort that she has. She also occasionally reports a doubling over-type, colicky problem that she notes often times while at home, even cooking dinner. It takes her away from her task at hand so it seems to be more than an insignificant, little problem.

The CAT scan today had oral and rectal contrast. It showed no evidence of any sinuses, no abscesses. She demonstrates no active evidence of any Crohn's disease. There is complete opacification of her bowel without any evidence of any obstruction.

There is only one other point to note, and that is that she has a left probable follicular cyst on the ovary, but not of significant size or concern.

At this point, it does not appear to be a surgical problem and it is not quite clear why she has this. I have discussed some dietary manipulations with her, including the avoidance of carbonated beverages, the appreciation of fiber and its relationship to gas reduction, as well as dairy products. She is going to make some necessary adjustments.

You may be hearing from her in the future if she continues to have problems. Please do not hesitate to call if you have any questions.

Most sincerely,

CareWeb CCC Information

Frank G. Opelka, MD, FACS
FGO:mlm
cc: Mary Delaney, MD

Written by OPELKA,FRANK on 05/09/03, signed on 05/13/03

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LUCEY,MARILYN:BIDMC Radiology Detail - CCC Record #1518504

FINAL REPORT

INDICATION: History of Crohn's disease, pain, fever.

TECHNIQUE: Contiguous axial images were obtained from the lung bases to the femoral heads after administration of 100 cc Optiray. Nonionic contrast was used secondary to patient allergy. Coronal reformations were performed. Additional images were obtained through the pelvis after the administration of rectal contrast.

COMPARISON: March 19, 2003.

CT ABDOMEN WITH CONTRAST: The lung bases are clear. The liver, gallbladder, spleen, pancreas, adrenals, and kidneys are unremarkable. There is no significant mesenteric or retroperitoneal lymphadenopathy. There is no free air or free fluid in the abdomen. The opacified loops of large and small bowel are unremarkable. There are no inflammatory changes to suggest active Crohn's disease. There is no evidence for an abscess or fistula.

CT PELVIS WITH CONTRAST: The distal ureters and bladder appear normal. The rectum and sigmoid appear normal after rectal contrast administration. There is significant stool throughout the colon. There is no significant pelvic lymphadenopathy. There is a left ovarian follicle identified.

Bone windows demonstrate no suspicious lytic or sclerotic abnormalities.

The above findings were confirmed with coronal reformations.

IMPRESSION:

No evidence for active Crohn's disease. No significant abnormalities identified.

THE STUDY AND THE REPORT WERE REVIEWED BY THE STAFF RADIOLOGIST.
DR. MICHAEL E. SCHUSTER
DR. VASSILIOS D. RAPTOPOULOS

Approved: SUN MAY 11,2003 8:44 PM
Procedure Date:05/09/03

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